Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HERMAN HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name

FIREMANS FUND INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-98-1142-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This dispute involves reimbursement under rule 134.400 now void. Carrier has refused reconsideration of reimbursement at fair and reasonable level. Minimum reimbursement should be at the minimum of the Facility Fee Ratio, 85% of billed charges, established by TWCC as fair and reasonable payment for services billed prior to September, 1992."

Amount in Dispute: $5,663.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bills were properly paid pursuant to the per diem rates and other provisions of the 1992 Acute Care Inpatient Hospital Fee Guideline ('Guideline'). …the Guideline was developed as a reasoned methodology for paying hospitals fair and reasonable fees for acute care inpatient treatment, while aiming for the cost containment also mandated by the Texas Workers Compensation Act. While the Guideline was invalidated as a TWCC rule based upon procedural error in its adoption, the per diem rates and methodology of the Guideline remain a valid measure of fair and reasonable hospital fee reimbursement for acute inpatient treatment."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 1997 through January 21, 1997	Inpatient Hospital Services	$5,663.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the

procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on August 1, 1997.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 224–Duplicate charge
   - D–Duplicate charge
   - DWCC 62: We are returning the enclosed bill which has been previously reimbursed in full under the provision of the Texas Workers Compensation Act. The fair and reasonable rate of reimbursement was determined by Rule 134.000 which was in effect at the time the services were incurred. While the rule has been invalidated based upon a procedural challenge, the basis of the rule and the commission determination that the rule provides for a fair and reasonable rate of reimbursement has never been revised.
   - 793–Reduction due to PPO contract
   - C–Negotiated contract

Findings

1. The carrier denied services using the denial code "C–Negotiated contract" and denial code "793–Reduction due to PPO contract." Review of the submitted documentation finds no copy of the contract or documentation to support a contractual agreement between the parties to this dispute. The Division concludes that these EOB denials are not supported. The services will therefore be reviewed per applicable statutes and Division rules.
2. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
3. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
4. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of medical documentation and EOBs or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
5. Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "This dispute involves reimbursement under rule 134.400 now void. Carrier has refused reconsideration of reimbursement at fair and reasonable level. Minimum reimbursement should be at the minimum of the Facility Fee Ratio, 85% of billed charges, established by TWCC as fair and reasonable payment for services billed prior to September, 1992."

- The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305(d). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 21, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.